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Dear Illinois Congressional Delegation:

To keep you informed on how the passage of the *Affordable Care Act* affects primary care physicians, specifically family physicians, I am sharing a synopsis of our comments to the "Medicare Shared Savings Program: Accountable Care Organizations" (CMS-1345-P) proposed rule as published in the April 7, 2011, Federal Register.

The Illinois Academy of Family Physicians, representing over 3800 family physicians and medical students, recognizes this proposed regulation as the first major health delivery reform initiative following the passage of the *Affordable Care Act*. As a longstanding supporter of efforts that improve the quality and efficiency of care and efforts that demonstrate an increased value of healthcare expenditures, we believe properly structured ACOs have the potential to help make the delivery system more accountable and more focused on value instead of volume.

However, IAFP is concerned that the Medicare ACO program as currently proposed will fail to offer the potential benefits of better care for individuals, better health for populations, lower per capita costs for Medicare beneficiaries and improved coordination among physicians. IAFP remains committed to working with CMS and the Congress to refine the Medicare Shared Savings ACO program to ensure its success.

Medicare ACO Eligibility

IAFP is quite concerned that, as currently proposed, only large and established integrated health systems that already possess the capital and infrastructure would be able to qualify as a Medicare ACO. Failing to attract small- to medium-sized practices, especially in rural settings but also in urban areas, will squander this tremendous opportunity to improve the healthcare delivery system and will deny the potential benefits of the ACO model to patients throughout the country, most of whom receive care from small and medium size physician practices.

IAFP has urged CMS to drastically reconsider its proposed Medicare ACO policies and instead offer greater flexibility so that small- to medium-sized primary care practices will be more eligible to participate. This would involve eliminating all but the essential requirements included in the statute (e.g., demonstrated ability to care for at least 5,000 beneficiaries, ability to measure and report on quality of care provided) and making the "one-sided model" truly one-sided. CMS's concern with the minutiae of ACO governance and management structure and marketing seems misplaced. If CMS focuses only on the essentials and allows ACOs to take shape in ways that make the most sense in their respective markets, then small- to medium-sized practices will have more opportunity to participate, and Medicare patients will reap the rewards of their doing so.

Medicare ACO Structure

IAFP does not believe that the Medicare ACO program can succeed if CMS confines its payment method to the current, traditional Medicare fee-for-service payments to ACO participants. Per the American Academy of Family Physicians [principles](#) on ACOs, we urged CMS to revise the proposed policies and instead employ a variety of payment approaches, such as blended fee-for-service payments, prospective payments, episode/case rate payments, and partial capitation payments. Sec. 3022 of the *Affordable Care Act* discusses a partial capitation model, yet CMS unaccountably did not include this model in the proposed regulation. IAFP believes continuing traditional fee-for-service payment on a day to day basis is an approach that lacks sufficient financial incentives to motivate ACO participants to improve the coordination of patient care. The incentives derived from potential shared savings, which the Medicare ACO may or may not receive many months after clinical care is provided, will be small in relation to the fee-for-service payments derived from visits or procedures, making it difficult for ACO management to effect the needed changes.

One of the main challenges for any ACO is to modify physicians' behaviors, and IAFP believes the best mechanism to achieve this is through immediate reinforcement in the form of payment for services provided directly in the office and indirectly through contacts like e-mail and telephone as well as a per-patient/per-month care management fee. Unless or until CMS is able to pay ACOs (and, in turn, facilitate ACOs paying their participants) in a manner more consistent with the desired outcomes (i.e., through a blend of fee-for-service, partial capitation, etc.), we do not believe the Medicare ACO program can succeed. We therefore encouraged CMS and the Center for Medicare and Medicaid Innovation to further consider and experiment with payment models outside the limitations of Sec. 3022.

IAFP is pleased that CMS proposes a requirement that at least 75 percent of a Medicare ACO's leadership and governance structure must consist of clinicians, administrative staff, and patients. Since Congress intended the Medicare ACO program to be based on a foundation of primary medical care, we urge CMS, in the final rule, to specify that the Medicare ACO governance structure must utilize primary care physicians in the top leadership positions to ensure that Medicare ACOs are primary care driven. Significant and equitable representation from primary care and specialty physicians in a Medicare ACO's administrative structure, policy development, and decision-making processes will help to ensure the program's success.

Also commendable is the requirement that all Medicare ACOs employ a board-certified physician, licensed in the state in which the ACO operates, who is physically present in an established ACO location and who serves as a senior-level medical director responsible for clinical management and oversight. Similarly, we supported the provision requiring all Medicare ACOs to employ a physician to direct the quality assurance and process-improvement committee. We concur with CMS that physicians, especially primary care physicians, serving in these leadership positions will promote continued quality improvement efforts.

Shared Savings Methodology

IAFP appreciates CMS offering risk-based options to potential Medicare ACOs, but we urged CMS to consider proposing additional options tailored for smaller medical practices. To encourage greater participation, IAFP recommended easing the 2 percent to 3.9 percent minimum savings rate, as these rates are too high to entice small- to medium- sized primary care practices, less familiar with assuming financial risk, to consider becoming part of a Medicare ACO. CMS should also eliminate the cap on shared savings. Doing so may increase interest and may improve participation in the program. The statute anticipates that professionals in group practice arrangements should be permitted to form Medicare ACOs. Requiring all Medicare ACOs to assume down-side risk in at least the third year will also discourage small- and medium-sized practices from forming a Medicare ACO. Mandatory risk-sharing for all Medicare ACO participants will be problematic, particularly as the Medicare ACOs will have no ability to identify their assigned beneficiaries or influence their behavior.

IAFP thus encouraged CMS to provide estimated expenditure benchmarks to entities prior to the formal ACO application process so that the prospective ACO participants can make a more informed business decision.

Quality Reporting Requirements

IAFP questioned why CMS proposed quality reporting requirements for the first year only, while requiring potential Medicare ACOs to commit to participating for three years. Instead, IAFP urged CMS to outline quality reporting requirements for the full three-year program. CMS must do this so that interested entities are fully aware of all Medicare ACO program requirements.

Furthermore, IAFP believes the number of initial quality measures is, at least for the first year, onerous and operationally unrealistic. We noted that the Physician Quality Reporting System only requires three measures, and the response to that program has not been overwhelming. We therefore urged CMS to specify clearer parameters pertaining to reporting on quality measures. Quality measure reporting must be handled with great care and must yield accurate, timely, and actionable data. The value of quality measures is to provide timely and actionable feedback to the Medicare ACO and its participating physicians so that they can then modify practices, behaviors and systems. Medicare ACOs should be allowed to choose which NQF endorsed quality measures apply to that ACO's covered population. CMS should only require Medicare ACOs to report on quality measures that improve population health outcomes and efficiency.

The *Affordable Care Act* does not require a hospital to be a part of a Medicare ACO. It is therefore puzzling that CMS proposes all Medicare ACOs must report a measure that incorporates 9 hospital acquired condition measures. The measure set should be limited to a more feasible list (e.g., 10 measures) in the first year, focusing on addressing high cost/high volume disease conditions, with the remaining measures phased-in over the three-year performance period. Another option is to have reporting requirements for the first year, without targets or penalties, and phase those in after year one or two. Furthermore, Illinois AFP has concerns over the proposed quality measure scoring process, the overall performance score, the performance benchmarks, and the minimum attainment level for each quality measure. This is an overly complicated process that should be significantly streamlined. These types of complexities further exclude smaller and less integrated primary care practices.

Role of Primary Care

We urged CMS to specify "general internal medicine" in the final Medicare ACO regulation to ensure that Medicare ACOs are truly based on primary care physicians. We proposed that the definition of primary care professionals for purposes of the Medicare ACO program only include "general internal medicine, general practice, family medicine, or geriatric medicine" in any of their specialty designation fields, primary, secondary or otherwise.

We further recommended that rather than list "primary care services," that CMS go further to state that the primary care professionals be limited to those eligible for Primary Care Incentive Payments as a matter of consistency and specificity across CMS policy. IAFP recognizes that some sub-specialists occasionally provide some primary care services. However, they are not providing continuing and comprehensive primary healthcare to their patients. IAFP would strongly oppose any further expansions of the definition of "primary care professional" for purposes of the Medicare ACO program.

IAFP believes the second option is the best of the three proposals; however, it limits primary care physicians to participate in only one Medicare ACO. For the Medicare ACO program to succeed, it is absolutely essential for CMS to identify alternative policies so that primary care physicians are able to participate in multiple Medicare ACOs.

IAFP recognizes CMS must assign Medicare fee-for-service beneficiaries to a specific ACO based on their utilization of primary care services. As proposed, the primary care physician with the plurality of visits determines to which Medicare ACO the patient is assigned, and if the primary care physician participated in two Medicare ACOs, confusion over to which one CMS should assign a patient may arise. However, this problem could be avoided by creating incentives (e.g., no deductibles and reduced co-insurance for

primary care physician services) for patients to prospectively identify a primary care physician in an ACO. The patients need to be accountable as well as the participating physicians and providers. Identification of a primary care physician does not have to limit patient choice in any way. It simply provides an alternative method for identifying the population of patients for which the ACO is responsible while getting more engaged patients to think about having a usual source of care.

Alternatively, CMS should prospectively allow patients to choose their own Medicare ACO. This would relieve CMS from the proposed and flawed beneficiary attribution method that currently limits primary care physicians to participate in only one Medicare ACO.

Involvement of Medicare Beneficiaries in an ACO

IAFP supported the flexibility offered to Medicare patients receiving care in a Medicare ACO. For instance, the agency specifies that participation of Medicare beneficiaries is completely voluntary and there is no automatic enrollment or assignment of beneficiaries to the Medicare ACO. The proposed regulation also allows Medicare beneficiaries to receive care outside of the Medicare ACO at no penalty to the patient.

IAFP concurred with the proposed requirements that Medicare ACOs notify patients at the point of care that their provider or supplier is participating as a Medicare ACO. We also agree with the proposed condition that Medicare ACOs must obtain a patient's permission to request that patient's Medicare claims data. According to the AAFP [principles](#) on ACOs, we believe patients receiving care in a Medicare ACO should be encouraged to prospectively select a primary care physician. We urged CMS to consider this as a resolution to the problem that, as currently proposed, primary care physicians could only participate in one Medicare ACO.

Participation in Rural Areas


Small- and medium-sized primary care practices in rural areas will encounter additional challenges with the Medicare ACO program. If they attempt to participate, they will be compelled to align with larger entities that possess the robust financial resources needed to fund health information technology infrastructure and sufficient reserves to fund any possible losses. For purposes of the Medicare ACO, rural primary care practices likely will not band together in an independent practice association (IPA) arrangement since IPAs, especially new IPAs, typically lack the needed financial reserves. A rural primary care practice could participate with the local hospital as a Medicare ACO. This is problematic as these small hospitals are not positioned to be successful ACOs.

To address the considerable challenges individual physicians in rural areas face, the IAFP urged CMS to consider further incentives, such as an enhanced fee-for-service payment and other payment methods (e.g., partial capitation), for joining a Medicare ACO. This rural primary care provider incentive could help to fund the infrastructure requirements of a Medicare ACO, buffer risk, and stimulate further participation. CMS should consider offering start-up grants or low-cost loans to entities wishing to create an ACO in a rural area. CMS must offer different Medicare ACO participation requirements for rural areas.

Thank you for allowing us to share with you our response to the CMS proposed rule on ACOs. IAFP believes properly structured ACOs have the potential to help make the delivery system more accountable and more focused on value instead of volume.

If you have any questions or need more information on this or other health care reform initiatives, please contact our executive vice president, Vince Keenan, vkeen@iafp.com or our deputy executive vice president for external affairs, Gordana Krkic, gkrkic@iafp.com

Sincerely,



David. J. Hagan, M.D.
President